DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/09/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPI	
			B. WIN	G _		04/08/2	011
NAME OF	DDOVIDED OD SLIDDI IED		'	STREET	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF	PROVIDER OR SUPPLIER			44 CHA	ATEAU BLVD		
	U OF BATESVILLE		_		VILLE, IN47006		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
R0000	Survey. This vis Investigation of On IN00087366 and Complaints IN00 and IN00087411 deficiencies relationed at R241, R2 Survey dates: Approvider number: AIM number: Note and Individual and Individual at R241, R2 Survey dates: Approvider number: AIM number: Note and Individual at Ind	Complaints IN00086981, IN00087411. 0086981, IN00087366 - Substantiated. State ed to the allegations are 247 and R297. pril 4, 5, 6, 7, and 8, 2011 006489 : 006489 /A N, TC RN (April 6 and 7, 2011) pe:		0000	Submission of this Plan of Correction does not constitute admission or agreement by the provider of the truth of facts alleged or corrections set forth the statement of deficiencies. This Plan of Correction is prepared and submitted becator of requirements under State Is	ne h on use	(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

H6Y911

Facility ID:

006489

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE 00 COMPI					
111,12,12,111	or conduction	DESTRUCTION DESCRIPTION OF THE PROPERTY OF THE	A. BUILDIN	IG		04/08/2	
			B. WING	TREET AI	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				TEAU BLVD		
CHATEA	U OF BATESVILLE				ILLE, IN47006		
(X4) ID		TATEMENT OF DEFICIENCIES	II		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PRE		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TA	AG	DEFICIENCY)		DATE
	accordance with	410 IAC 16.2-5.					
R0086	Quality review 4. Williams, RN The licensee: (1) is responsible to applicable laws; an (2) has full authority (A) organization; (B) management; (C) operation; and (D) control; of the licensed factor The delegation of licensee does not of the licensee. Based on interviet facility failed to expect the contesting must hold certificate. This potential to affect identified as diab	The licensee: (1) is responsible for compliance with all applicable laws; and (2) has full authority and responsibility for the: (A) organization; (B) management; (C) operation; and (D) control; of the licensed facility. The delegation of any authority by the licensee does not diminish the responsibilities			The application for a CLIA waiver Certificate has been initiated on April 15, 2011, to ensure compliance with CLIA regulations. The facility shall ensure licensed nurses hold a valid Indiana licensure in order to practice as an Indiana licensed nurse. Other residents having the potential to be affected and corrective actions: This deficient practice has the potential to affect all 10 residents identified as diabetics.		05/29/2011
	•	ployed at the facility.			Measures to ensure practice		
	-	actice has the potential to			does not recur: All new hires must provide a valid Indiana		
	-	the care of all residents.			license or certificate before the	ey	
	Findings include				work any shifts. This corrective action will be monitored by: The office manager shall verify each license and/or certificate www.mylicense.in.gov/everificate	ve , on	
	•	with the current Director,			n prior to employment.	สแบ	
				l			

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUII		00	04/08/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	0 1/00/2	
NAME OF I	PROVIDER OR SUPPLIER	ŧ			TEAU BLVD		
CHATEA	U OF BATESVILLE				VILLE, IN47006		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		e was unsure if the facility					
		ver. On 4-5-11 at 9:27					
	•	ed she could not find such					
	a CLIA waiver document. She indicated						
	that according to her [administrator's]						
	manual, the facility should have one						
	because they conduct fingersticks for						
	blood sugars.						
	2. During review	w of the employee files on					
	4-7-11, documentation indicated LPN #1						
	did not have a valid Indiana license to						
	practice as a practical nurse.						
	Documentation i	ndicated she held a valid					
	license as a licen	sed practical nurse (LPN)					
	in the state of Oh	nio. Documentation of an					
	unsigned applica	tion for an Indiana					
	license was prov	ided on 4-7-11 which was					
	dated 4-5-11. In	interview with the					
	Director of Nurs	ing (DON) on 4-7-11 at					
	3:30 p.m., she in	dicated she thought the					
	-	4 months in which to					
	obtain the curren	at state's licensure.					
	Documentation p	provided by the facility on					
	4-7-11 indicated	LPN #1 had worked in					
	the facility in the	e capacity of an LPN					
	during the time p	period 3-7-11 through					
	3-13-11 for 30.30	0 hours.					
R0117		sufficient in number,					
		I training in accordance with					
		aws and rules to meet the our scheduled and					
		ds of the residents and					
	services provided	. The number,					
	qualifications, and	training of staff shall					
			_				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 04/08/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 44 CHATEAU BLVD CHATEAU OF BATESVILLE BATESVILLE, IN47006 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. R0117 As a means to ensure ongoing 05/29/2011 Based on record review and interview, the compliance, the State facility failed to ensure adherence to Ruleaddressing CPR and First regulations regarding having at least one Aid Certification has been employee with CPR (cardiopulmonary reviewed with the administrative staff of the facility to resuscitation) and first aide training on ensureunderstanding of said rule. site at all times. This deficient practice Corrective action for residents has the potential to adversely affect all affected: This deficient practice residents. has the potential to adversely affect all residents. All employee files are being audited. Employees Findings include: who do not have a valid First Aid Certificate and a valid CPR Review of 33 employee records indicated Certificate will attend the First Aid and CPR Training Classes only 3 current employees have both CPR conducted by The American and first aide training. Of the 3 Heart Association on April 26th employees, none were nursing staff. The and 27th, 2011. Other residents 3 current employees with both CPR and having the potential to be affected first aide training, 2 were dietary staff and corrective actions: This deficient practice has the (Dietary Staff #9 and Dietary Staff#10) potential to adversely affect all

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NAME OF PROVIDER OR SUPPLIER CHATEAU OF BATESVILLE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) and 1 was housekeeping staff (Housekeeper #8). In interview with the Director of Nursing on 4-8-11 at 3:35 p.m., she indicated the facility thought the licensure and training of the [licensed] nurses would cover the requirements for first aide and CPR. Taging and CPR. STREET ADDRESS, CITY, STATE, ZIP CODE 44 CHATEAU BLVD BATESVILLE, IN47006 ID PROVIDERS PLAN OF CORRECTION (X5) COMPLETION (EACH CHOINE) COMPLE	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
A4 CHATEAU BLVD BATESVILLE (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG and I was housekeeping staff (Housekeeper #8). In interview with the Director of Nursing on 4-8-11 at 3:35 p.m., she indicated the facility thought the licensure and training of the [licensed] nurses would cover the requirements for first aide and CPR. Taging the properties of the properties				B. WING		04/08/2011
PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) and 1 was housekeeping staff (Housekeeper #8). In interview with the Director of Nursing on 4-8-11 at 3:35 p.m., she indicated the facility thought the licensure and training of the [licensed] nurses would cover the requirements for first aide and CPR. PREFIX TAG residents. All employee files are being audited. Employees who do not have a valid First Aid Certificate and a Valid CPR Certificate will attend the First Aid and CPR Training Classes conducted by the American Heart Association on April 26th and 27th, 2011. Measures to ensure practice does not recur: Personnel shall be assigned only those duties for which they are trained and oriented to perform. Employee duties shall conform to written facility job descriptions. This corrective action will be monitored by: The Resident Health and Services Director and facility Administrator shall meet on a monthly basis to				44 CH	ATEAU BLVD	
and 1 was housekeeping staff (Housekeeper #8). In interview with the Director of Nursing on 4-8-11 at 3:35 p.m., she indicated the facility thought the licensure and training of the [licensed] nurses would cover the requirements for first aide and CPR. The requirements for first aide and CPR. The residents. All employee files are being audited. Employees who do not have a valid First Aid Certificate and a valid CPR Certificate will attend the First Aid and CPR Training Classes conducted by the American Heart Association on April 26th and 27th, 2011. Measures to ensure practice does not recur: Personnel shall be assigned only those duties for which they are trained and oriented to perform. Employee duties shall conform to written facility job descriptions. This corrective action will be monitored by: The Resident Health and Services Director and facility Administrator shall meet on a monthly basis to	PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	COMPLETION
R0121 (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least		and 1 was housel (Housekeeper #8 In interview with on 4-8-11 at 3:35 facility thought the facility the facility must assure (1) At the time of the facility must assure (1) At the time of the facility must assure (1) At the time of the facility must assure (1) and the facility must assure (1) At the time of the facility must assure (1) and the facility must ass	the Director of Nursing p.m., she indicated the he licensure and training nurses would cover the first aide and CPR. Is shall be required for each elity prior to resident contact. Include a tuberculin skin into method (5 TU, PPD), y positive reaction can be result shall be recorded in ration with the date given, whom administered. The ethe following: employment, or within one	TAG	residents. All employee files being audited. Employees whot have a valid First Aid Certificate and a valid CPR Certificate will attend the First and CPR Training Classes conducted by the American Massociation on April 26th and 27th, 2011. Measures to ensure practice does not recur: Personnel shall be assigned those duties for which they a trained and oriented to perform Employee duties shall conform written facility job descriptions. This corrective action will be monitored by: Resident Health and Service Director and facility Administ shall meet on a monthly basing review all employees and vertification as required the Residential Rule. The Off Manager will be responsible monitor for certification of employees upon hire and representation in the services of the properties of the residential Rule. The Off Manager will be responsible monitor for certification of employees upon hire and representation needs to Reside Health and Services Director	are no do at Aid Heart dure only re rm. rm to The s rator s to rify rst by fice to port nt

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	04/08/2011	
			B. WING		04/00/2011	
NAME OF F	PROVIDER OR SUPPLIER		I .	T ADDRESS, CITY, STATE, ZIP CODE		
OLIATEA	05 5 4 7 5 0 /// . 5			HATEAU BLVD		
CHAIEA	U OF BATESVILLE		BAIE	SVILLE, IN47006		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
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	•	ties shall be screened for first tuberculin skin test				
		r to the employee starting				
	•	are workers who have not				
		d negative tuberculin skin				
		he preceding twelve (12)				
		ine tuberculin skin testing				
		e two-step method. If the ve, a second test should be				
	performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will					
	depend on the risk					
	tuberculosis.					
	(2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and					
		ations in order to complete				
	a diagnosis.	ations in order to complete				
		all maintain a health record				
		that includes reports of all				
		ed health screenings.				
		with symptoms or signs of				
		ymptoms suggestive of s, including, but not limited				
		ight sweats, and weight				
		permitted to work until				
	tuberculosis is rule	ed out.				
	Based on record	review and interview, the	R0121	All employee files are	05/29/2011	
	facility failed to	ensure 3 of 5 employees		beingaudited and employees didnot have a negative Manto		
	had timely Mante	oux (TB) testing and 1 of		within the past year will receive		
	5 employees had	health screenings		the step 1 and step 2 Mantou		
	(physical examinations) conducted prior to employment. This deficient practice			testing conducted in adheren		
				with the State Rule. As a mea		
		to adversely affect all		to ensure on going compliance	e,	
	•	Director, Dietary Staff #6		the State Rule addressing Mantoux testing has been		
	and CNA #7)	interest, Diemir Guil 110		reviewed with the administrati	ive	
				staff of the facility to	· [
	Eindings instal			ensureunderstanding of	[
	Findings include	•		compliance withthe State	_ [
				Rule.Measures to ensure pra	ctice	

006489

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE S COMPLE - 04/08/20	ETED
	PROVIDER OR SUPPLIER		44 CH/	ADDRESS, CITY, STATE, ZIP COE ATEAU BLVD WILLE, IN47006	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	within the last 12 did not have Mar within the month (Site Director, D #7) This review employees did not in the month price Director #5). In interview with 4-7-11 at 4:00 p.s was not required position. In interview with on 4-7-11 at 4:22 had not found all	aployees employed to days, 3 of 5 employees atoux testing conducted prior to employment. The days of the employment of the Site Director on the employment (Site of the Site Director on the employment of the Director of Nursing of the Director of Nursing of the employee TB continue to look for the		does not recur: The Offic Manager will report the emantoux testing needs to Resident Health Service in order to maintain, mor coordinate appropriate to employees at the time of employees at the time of employment or within 1 and at least annually the This corrective action with monitored by: The Resident Health and Services Directly the facility Administrator on a monthly basis to refemployees to verifycomy with mantoux testing as by the residential rule.	employee o the s Director nitor and esting of f month ereafter. Il be dent ector and willmeet view all bliance	
R0123	accurate personnel recinclude the followi (1) The name and (2) Social Security (3) Date of beginn (4) Past employment education, if applic (5) Professional lic number or dining a of completion, if a (6) Position in the (7) Documentation	address of the employee. number. ing employment. ent, experience, and cable. censure or registration assistant certificate or letter				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 04/08/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 44 CHATEAU BLVD CHATEAU OF BATESVILLE BATESVILLE, IN47006 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
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DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with facility policy. (10) Date and reason for separation. The facility shall maintain current Based on interview and record review, the R0123 05/29/2011 and accurate personnel facility failed to ensure current Indiana recordsfor all employees. licensure for 1 Licensed Practical Nurse Personnel records shall include (LPN). The deficient practice has the the name and address of the employee, Social Security potential to adversely affect the care of all number, date ofbeginning residents. (LPN #1) employment, past employment, experience, and education, Findings include: professional licensure or registration number or dining assistant certificate or letter of During review of the employee files on completion, position in the facility 4-7-11, documentation indicated LPN #1 and job description, did not have a valid Indiana license to documentation of orientation to the facility, including residents' practice as an LPN. Documentation rights, signed acknowledgement indicated she held a valid license as an of orientation to residents' rights, LPN in the state of Ohio. Documentation performance evaluations in of an unsigned application for an Indiana accordance with facility policy, date and reason for separation. nursing licensure was provided on 4-7-11 Corrective action for residents which was dated 4-5-11. affected:The deficient practice has the potential to adversely In interview with the Director of Nursing affect the care of all residents. (DON) on 4-7-11 at 3:30 p.m., she The facility shall ensure current Indiana licensure, prior to indicated she thought the nursing staff had employment. Other residents 4 months in which to obtain the current having the potential to be affected state's licensure. Documentation provided and corrective actions:The by the facility on 4-7-11 indicated LPN #1 deficient practice has thepotential to adversely affect the care of all had worked in the capacity of an LPN in residents. The facility shall ensure the facility during the time period 3-7-11 current Indiana licensure, prior to through 3-13-11 for 30.30 hours. employment.

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUIL B. WINC	DING	00 	COMPL 04/08/2	ETED	
	PROVIDER OR SUPPLIER		'	44 CHA	DDRESS, CITY, STATE, ZIP CODE TEAU BLVD /ILLE, IN47006		
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R0217	facility, using apprimembers, shall id services to be profollows: (1) The services of resident shall be at (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services of and revised as appeared to the request a service (3) The agreed upsigned and dated of the service plar resident upon request a service of the services provided subsequent to the no need for a characteristic provision of reside both, is needed, at the services and the service provision of reside both, is needed, at the services and the services provided subsequent to the no need for a characteristic provision of reside both, is needed, at the services and the services provided subsequent to the no need for a characteristic provision of reside both, is needed, at the services are services and the services are services and the services are services are services and the services are service	ffered shall be reviewed propriate and discussed by acility as needs or desires a facility or the resident may plan review. on service plan shall be by the resident, and a copy a shall be given to the uest. In and documentation of is needed if evaluations initial evaluation indicate ange in services. In of medications or the ential nursing services, or licensed nurse shall be cation and documentation					
	Based on observer record review, the identify and door provided for 2 of regarding conduction checks for videntify and door of 7 sampled residents.	ation, interview and e facility failed to ment the services to be 7 residents sampled cting hourly or every 2 well being; failed to ment the services for 1 dents requiring Level 3 o follow the service plan	R0:	217	The facility has identified anddocumented services provided appropriate to the scope, frequency, need and preference of each resident. Corrective action for residents affected: Residents # #38 and #A: Unable to correct clinical record. Based on clinical record review, the facility has identified and documented	the	05/29/2011

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF F	PROVIDER OR SUPPLIER	8			TEAU BLVD		
CHATEA	U OF BATESVILLE				VILLE, IN47006		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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	* *	mental sampled residents			services provided to each resident on their individual ser	vice	
	who had been de				plans.Other residents having t		
	self-administer n	nedications who was			potential to be affected and		
	found to have unlabeled, non-physician				corrective actions:All residents	;	
	ordered medications unsecured in their				have the potential tobe affecte		
	room. (Resident	s #4, #38 and #A)			by this deficient practice. Base	d	
					on clinical record review, the facility has identified and		
	Findings include	:			documented services provided	l to	
	Findings include.				each resident on their individua		
	Resident #38's clinical record was				service plans. Measures to		
	reviewed 4-4-11 at 11:45 a.m. Her				ensure practice does not		
	diagnoses included, but were not limited				recur:The Resident Services		
	_	diabetes mellitus type 2,			Director or designee will review requireddocumentation and	V	
					evaluations to accurately ident	ifv	
	_	failure and coronary			services provided. On April 27	-	
		Review of the nursing			2011 allnursing staff was		
		nultiple documentation			inserviced on Resident Service		
		and 3-29-11 of the			Planning. This corrective actio will be monitored by:The Directive		
	_	necked on an hourly to			of Health Servicesor designee		
	_	is. Documentation on			be responsible for completing a		
	3-29-11 indicated	d discontinuation of			clinical record audit of all		
	"safety checks."	Additional			residents weekly for 4 weeks,		
	documentation o	n a "Safety Checks			then every other week for8		
	Form" which beg	gan on 3-6-11 and			weeks, then monthly for 3 months. Results will be reported	-d	
	continued through	gh 3-29-11 indicated the			to the QA team for review and	Ju	
	-	e to conduct these checks			further corrective actions as		
	_	frame, such as hourly or			deemed necessary.		
		Review of Resident #38's					
	-	ted 3-22-11 did not					
	· ·	eation of the reason for					
		ty checks nor the					
		e safety checks to be					
		sarcty checks to be					
	conducted.						
	2. Resident #4's	room was toured on					

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			B. WIN			04/06/2	011
NAME OF	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
CHATE	AU OF BATESVILLE				ATEAU BLVD VILLE, IN47006		
					1		
(X4) ID PREFIX	1	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	I '	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	DATE
	+	m. with the Maintenance		-			
	1	Director during the					
		our. During this tour, 3					
		ne counter medications,					
	labeled as Tylenol, Pepto Bismol and						
	MegaRed, were observed on the kitchen						
	counter near the kitchen sink. These						
	bottles were observed to have only the						
	manufacturer's label on them.						
	manatactarer s laber on them.						
	In review of her clinical record on 4-6-11						
	at 3:20 p.m., a "Medication Assessment"						
	1 .	1-10, indicated the					
	· ·	med unable to safely					
		ny of her medications					
		n memory loss and res					
		t correctly state what					
	1 ' ′	ns) are for or times to					
		iew of the recapitulation					
		2011 did not include these					
	1 ^	eing ordered by the					
	physician.	omg ordered by the					
	parjorani.						
	3. Resident #A's	record was reviewed on			The facility has identified		05/29/2011
	1	.m. The record indicated			anddocumented services		
		admitted with diagnoses			provided appropriate to the		
		t were not limited to,			scope, frequency, need and preference of each		
	•				resident.Corrective action for		
	_	-			residents affected:Residents #		
	I -	<i>G</i> -3 <i>C</i>			#38 and #A:Unable to correct		
						aı	
	During an intervi	iew on 4/4/11 at 10:30			identified and documented		
	1				services provided to each		
	1 '	due to being a fall risk,			resident on their individual ser	vice	
	diabetes, high blo in leg, dementia, failure. During an intervi a.m., CNA #2 ind	ood pressure, blood clot and congestive heart iew on 4/4/11 at 10:30 dicated resident #A was			resident.Corrective action for residents affected:Residents # #38 and #A:Unable to correct clinicalrecord. Based on clinical record review, the facility has identified and documented	the al	

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	00 00	(X3) DATE SURVEY COMPLETED 04/08/2011
			B. WING		04/08/2011
	PROVIDER OR SUPPLIER		44 C	ET ADDRESS, CITY, STATE, ZIP CODE HATEAU BLVD ESVILLE, IN47006	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
R0241	assistance. A "LEVEL OF CODETERMINATION indicated Resider assessment determed assessment determed assistance for a living. Review of the service or the assisted living or the assisted living. (e) The administration of resider as ordered by the shall be supervised the premises or or (1) Medication shall be assisted or the shall be supervised the premises or or (1) Medication shall be supervised the premises of	ON" dated 2/11/11 Int #A's functional Inined the resident to be a requires the highest level In resident in assisted Twice plan failed to Item for the hourly checks Item for the hour		plans.Other residents having potential to be affected and corrective actions:All resident have the potential tobe affecte by this deficient practice. Base on clinical record review, the facility has identified and documented services provide each resident on their individus service plans. Measures to ensure practice does not recur:The Resident Services Director or designee will revier requireddocumentation and evaluations to accurately idenservices provided. On April 27 2011 allnursing staff was inserviced on Resident Service Planning. This corrective action will be monitored by:The Directof Health Servicesor designee be responsiblefor completing clinical record audit of all residents weekly for 4 weeks, then every other week for weeks, then monthly for 3 months. Results will be report to the QA team for review and further corrective actions as deemed necessary.	s ed ed ed d to ual w tify 7, ee on ctor e will a
	interview, the fac	review, observation and illity failed to administer dered by the physician in	R0241	Administration of medications the provision of residential nursing care shall be as R 24 ordered by the resident's	03/27/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
			B. WIN			04/08/20	011
NAME OF I	PROVIDER OR SUPPLIER		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIER			44 CHA	ATEAU BLVD		
	U OF BATESVILLE				VILLE, IN47006		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TΕ	COMPLETION
TAG	!	LSC IDENTIFYING INFORMATION)	-	TAG			DATE
		nad missed doses of			physician.Corrective action for residents affected: Residents		
	medications (Re	sidents #A, C, D, and 34),			C, D, and34: Unable to correct		
	and 1 resident had unprescribed				the clinical record. The facility	`	
	medications that were unlabeled and unsecured (Resident #4). This affected 3 of 7 residents reviewed for medication administration in a sample of 7 and 2 of 2 residents in a supplemental sample of 2. Findings include:				shall administer medications a	ıs	
					ordered by the physician.Othe		
					residents having the potential	to	
					be affected and corrective actions:All residents, to which,		
					thefacility administers	,	
					medications, have the potentia	al to	
					be affected by this deficient		
Findings include.					practice. Policies and procedu	res	
	A policy and procedure for				relative to Medication		
					Management are in place to	_	
	"MEDICATION ERROR", with a revised				ensure professional standards		
	date of February	2006, was provided by			medication administration. On April 27, 2011all staff qualified		
	the Director of F	Health Services on 4/8/11			administermedications were	10	
	at 1:05 p.m. The	e policy included, but was			inserviced on Medication		
	not limited to: "	ALL medication errors			Management. Measures to		
	that occur for res	sidents receiving			ensure practice does not		
		agement services from the			recur:Policies and procedures		
		red to be recorded.			relativeto Medication Management are in place to		
	1 -	agement includes:			ensure professional standards	of I	
		p, reminders, assistance			medication administration. On		
		stration (ex. cuing) and			April 27, 2011 all staff qualified		
		`			administer medications were		
		y licensed staff. A			inserviced on Medication		
		includes: wrong			Management.This corrective action will be monitored by:Th	_	
		ng dosage, wrong			Director of Health Servicesor	-	
	timewrong rou	ite, missed medication.			designee will be responsible for	or I	
		Error Report form must			completing a clinical record au		
	be completed ea	ch time an error is			of all residents weekly for 4		
	discovered. AL	L medications involved in			weeks, then every other week		
	the incident mus	t be listed on the second			for8 weeks, then monthly for	tod	
	page of the repor	rt formAll other			3months. Results will be report to the QA team for review and		
		s shall be recorded on the			further corrective actions as		
		r report and kept on file			deemed necessary.		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION		E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00		PLETED
			B. WIN			04/08/	2011
NAME OF I	PROVIDER OR SUPPLIER			1	DDRESS, CITY, STATE, ZIP CODE		
CHATEA	U OF BATESVILLE			1	TEAU BLVD /ILLE, IN47006		
				L	VILLE, IN47000		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETION DATE
1710		ator's office for ISDOH	+	1710			DITTE
	review"	nors office for 15DO11					
	Teview						
	 1. Resident #A's	record was reviewed on					
	4/4/11 at 11:24 a.m. The record indicated						
	Resident #A was admitted with diagnoses						
	that included, but were not limited to,						
	diabetes, high blood pressure, depression,						
	blood clot in leg,	dementia, and					
	congestive heart						
	Physician's orders for medications for						
	March 2011, indicated orders for the						
	following medica	ations:					
	- Acetaminopher	n 650 mg (milligrams)					
		ry morning (for pain)					
		units/ml (milliliter) vial					
	· ` `	cutaneous) every					
	I -	or at breakfast (for					
	diabetes)						
	_	ng table, take 2 tablets					
	daily (for diabete						
	1 *	g tablet, one tablet daily					
	(for blood pressu						
	(for depression)	mg tablet, take 1 daily					
		g, take 1 tablet daily by					
		cerebellar infarct)					
	1 ' ` `	ng, take 1 capsule by					
		high blood pressure)					
	1 ,	m 4.5 mg every day (One					
		one 2.5 mg tablet) (for					
	blood clot in leg)	• , ,					
	· · · · · · · · · · · · · · · · · · ·	g by mouth daily (for					
	Donepezii 5 iiig	5 03 mount dumy (101		ļ			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S COMPL	
ANDILAN	or correction	IDENTIFICATION NUMBER.	A. BUIL		00	04/08/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	2			TEAU BLVD		
CHATEA	U OF BATESVILLE			1	VILLE, IN47006		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TΕ	COMPLETION
TAG	1	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCT)		DATE
	dementia)	1 11 11					
	1	mg by mouth two times a					
	1 ' '	ood pressure and edema)					
	1 -	tra strength caplet, 2					
	caplets at bedtin	ne (for pain/sleep)					
	Medication adm	inistration records					
		rch 2011 indicated the					
	1 '	ations had been initialed					
	1	ials circled to indicate the					
		not been give on March 5:					
		m, both the 2 mg and the					
	2.5 mg tablets	in, ooth the 2 mg and the					
	- Aricept 5 mg						
	- Furosemide 80	ma					
	- Tylenol PM 2 t	-					
		aulcts					
	The explanation	on the back of the MARs					
	1 *	5/11 5 & 8 pm pills [not]					
	1	ing on counter this am."					
	2. Resident #C's	s record was reviewed on					
	4/6/11 at 11:25 a	.m. The record indicated					
	resident #C was	admitted with diagnoses					
	that included, bu	it were not limited to,					
	pacemaker, oste	oarthritis, high blood fats,					
	_	ngestive heart failure,					
	1 -	high blood pressure,					
	1	ive pulmonary disease					
	(COPD), and ba						
		-					
	Physician's orde	rs for medications for					
	1 -	indicated orders for the					
	following medic	ations:					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO.	NSTRUCTION	COMPI	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUI	LDING	00	04/08/2	
			B. WIN	_		04/06/2	.011
NAME OF J	PROVIDER OR SUPPLIEF	8		1	ADDRESS, CITY, STATE, ZIP CODE		
OLIATEA	OF DATEO, #1.1 F			1	TEAU BLVD		
CHATEA	U OF BATESVILLE			BATES	VILLE, IN47006		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ng 1 each morning (for					
	COPD)						
		88 mcg (micrograms) 1					
	tablet daily (for l						
	- Docusate sodiu	m 100 mg 1 tablet daily					
	(for constipation						
	- Amiodarone 20	00 mg 2 tablet daily (for					
	pacemaker)						
		g 1 tablet daily (for high					
	blood pressure)						
	- Metoprolol 25	mg 1 tablet 2 times a day					
	(for congestive h	neart failure)					
	- Calcium + D 60	00 mg 1 tablet 2 times a					
	day (for osteoart	hritis)					
	- Furosemide 40	mg 1 tablet 2 times a day					
	(for congestive h	neart failure)					
	- Crestor 5 mg 1	tablet once a day at					
	bedtime (for high	h blood fats)					
	- Fentanyl 25 mc	eg/hour patch, apply one					
	patch to skin eve	ery 72 hours (for pain)					
	•	• • •					
	MARs for Febru	ary 2011 indicated the					
		ations had been initialed					
	I -	ircled which indicated the					
	medication had r						
		28: Crestor, with the					
	I -	d [not] available" on the					
	back of the MAF						
		d 22 at 8:00 a.m. and					
	1	:00 p.m.: Furosemide,					
	1 -	tion "[not] available" on					
	the back of the N						
	lie odek of the N						
	MARs for March	n 2011 indicated the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL 04/08/2	
			B. WIN			04/06/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
СНАТЕА	U OF BATESVILLE				TEAU BLVD VILLE, IN47006		
					VILLE, IIV+7 000		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	following medica	ations had been initialed					
	as not given:						
		6, and 10: Crestor, with					
	· -	on the back of the MAR					
	of "med [not] ava						
	On March 4 the	Fentanyl 25 mcg/hr patch					
	· ·	applied, and the box for					
		ssed out; the Fentanyl					
	1 *	ed as applied on March					
	1 ^	ation on the back of the					
	_	"3/3/11 Fentanyl patch -					
		3/5/11 8A patch signed					
	1 ^	t put on laying on					
	counter."	The state of the s					
	During an intervi	iew on 4/7/11 at 10:30					
	~	of Health Services					
	indicated a medic	cation discrepancy report					
		written for the Fentanyl					
		hanged when due.					
		-					
	3. Resident #D's	record was reviewed on					
	4/5/11 at 2:05 p.r	 The record indicated 					
	1	admitted with diagnoses					
		t were not limited to,					
		ar disease, depression,					
	^ ^	ase, high blood pressure,					
		amin B-12 deficiency,					
	constipation, and						
	Physician's order	rs for medications for					
	l -	ndicated orders for the					
	following medica						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2)	MULTIPLE CO			(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	А. В	UILDING	00	l	COMPL	
			B. W	/ING			04/08/2	011
NAME OF E	PROVIDER OR SUPPLIER	•		STREET A	DDRESS, CITY, STA	ATE, ZIP CODE		
					TEAU BLVD			
CHATEA	U OF BATESVILLE			BATES\	/ILLE, IN47006			
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID		PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PERCEDED BY FULI		PREFIX	CROSS-REFERENC	VE ACTION SHOULD BE CED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	N)	TAG	DEI	FICIENCY)		DATE
	_	mg 1 capsule at bedtime						
	(for insomnia)							
		1 tablet daily (for high						
	blood pressure)							
	*	azide 25 mg, 1/2 tablet						
	daily (for high bl	. /						
		,000 mcg tablet daily (for	r					
	B-12 deficiency)							
	- Paroxetine 20 m	ng daily (for depression)						
	MARs for Februa	ary 2011 indicated the						
	following medica	ations had been initialed						
	and the initials ci	ircled which indicated the	,					
	medication had n	not been given:						
		emazepam, with the						
	· ·	ne back of the MAR						
	"[not] available".							
	- February 20: A							
	I -	ne back of the MAR						
	"[not] available".							
		d 21: Vitamin B-12, with	,					
	1	on the back of the MAR	'					
	"[not] available".							
), 21: Paroxetine, with						
	1							
	_	on the back of the MAR						
	"[not] available".							
	1 Dagidant #241	s record was reviewed on						
		.m. The record indicated						
	Resident #34 was							
	l ~	cluded, but were not						
	limited to, high b	•						
		l reflux disease, high						
	cholesterol, pulm	nonary high blood						
FORM CMS-2	2567(02-99) Previous Version	ons Obsolete Event II	D: H6Y9 1	11 Facility I	D: 006489	If continuation sh	eet Pa	ge 18 of 44

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE S		
			A. BUILDIN B. WING	G		04/08/2	011
	PROVIDER OR SUPPLIER		ST 44	4 CHA	DDRESS, CITY, STATE, ZIP CODE TEAU BLVD //LLE, IN47006		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	III PRE	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TA	.G	DEFICIENCY)		DATE
	pressure, depress degeneration, and fibrillation.	ion, arthritis, macular gina, and atrial					
	March 2011, indifollowing medica						
	(anemia)	325 mg, 1 tab every day llequivalents, 1 tab twice					
	a day - Alendronate so						
	day - Diltiazem 24 hı	ER, 150 mg, 1 capsule					
		ICL 180 mg, 1 every day					
	- Paroxetine 20 n	mg, 1 tab at bedtime ng, 1 tab every day					
		mg, 1 tab twice a day mg, 1 tab at bedtime					
	(high cholesterol - Fosamax 70 mg) g, 1 tab every Saturday					
	(osteoporosis) - Omeprazole 20	mg, 1 tab daily (GERD)					
	- Hydrocodone/a times a day (pain	pap 10/325, 1 tab four)					
		ary 2011 indicated the					
	and the initials ci	ations had been initialed reled which indicated the					
	medication had n	•					
		and 28: Alprazolam 0.5					
l		lanation on the back of available" for the 3/24					

006489

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MI A. BUII		onstruction 00	COMPL	LETED	
			B. WIN	G		04/08/2	011
	PROVIDER OR SUPPLIER		•	44 CHA	ADDRESS, CITY, STATE, ZIP CODE NTEAU BLVD VILLE, IN47006	•	
(X4) ID PREFIX TAG	(EACH DEFICIENT REGULATORY OR dose. The 3/25 d	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) lose had no explanation		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	why it had not be A medication dis 3/29/11 indicated 3/28/11 had been 5. Resident #4's reviewed on 4-6- diagnoses include to atrial fibrillation fatigue, macular problems), and an Resident #4's room at 2:45 p.m. with Director and Site environmental to bottles of over-the labeled as Tylend MegaRed, were of counter near the Review of the cu orders for April 2 Resident #4 was receive Tylenol, MegaRed (an her Review of a door "Medication Assessigned and dated resident and facil assessment indicate been deemed una	crepancy report dated I the Alprazolam dose for omitted. clinical record was 11 at 3:20 p.m. Her ed, but were not limited on (irregular heartbeat), degeneration (vision rthritis. om was toured on 4-6-11 the Maintenance Director during the ur. During this tour, 3 the counter medications, ol, Pepto Bismol and observed on the kitchen kitchen sink. rrent recapitulation 2011 did not indicate physician-ordered to Pepto-Bismol or rbal supplement.) timent entitled, tessment," which was on 10-21-10 by the			Administration of medications the provision of residential nursing care shall be as R 24 ordered by the resident's physician. Corrective action for residents affected: Residents C, D, and34: Unable to correct the clinical record. The facility shall administer medications a ordered by the physician. Other residents having the potential be affected and corrective actions: All residents, to which the facility administers medications, have the potential be affected by this deficient practice. Policies and procedure lative to Medication Management are in place to ensure professional standard medication administration. Or April 27, 2011all staff qualified administermedication Management. Measures to ensure practice does not recur: Policies and procedures relativeto Medication Management are in place to ensure professional standard medication administration. Or April 27, 2011 all staff qualifie administer medications were inserviced on Medication were inserviced on Medication were inserviced on Medication were inserviced on Medication were inserviced on Medications were inserviced on Medication	fr #A, ct / asser to l, all to ures	05/29/2011

006489

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE	ECONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
			B. WING		04/08/2011	
NAME OF P	ROVIDER OR SUPPLIER		l l	ET ADDRESS, CITY, STATE, ZIP CODE		
CHATEAL	LLOE DATECVILLE			HATEAU BLVD		
_	U OF BATESVILLE		BAII	ESVILLE, IN47006		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE	
IAU			IAG	Management.This corrective	DATE	
	-	to identify what the for and when she should		action will be monitored by:Th	e I I	
				Director of Health Servicesor		
		ons. In an interview		designee will be responsible for		
		of Nursing on 4-6-11 at		completing a clinical record au of all residents weekly for 4	dit	
	•	dicated the facility had		weeks, then every other week		
	•	the medications from the		for8 weeks, then monthly for		
	resident's room a			3months. Results will be report	ted	
		an in order to get		to the QA team for review and		
		al for these medications		further corrective actions as deemed necessary.		
	to be administered to her.			accinica necessary.		
	This Clats Deside	antial Dala Carling aslates				
		ential Rule finding relates				
	•	00086981, IN00087366,				
	and IN00087411.	•				
R0247	(7) Any error in me	edication administration				
		ne resident 's record. The				
		notified of any error in stration when there are any				
		detrimental effects to the				
	resident.					
	Based on record	review and interview, the	R0247	Any error in medication	05/29/2011	
	facility failed to	ensure errors in		administration shall be noted inthe resident 's chart. The		
	medication admir	nistration were		physician shall be notified		
	documented in th	ne resident's record for 3		immediately of any error		
	of 7 residents in a	a sample of 7 and 1 of 2		inmedication administration		
	residents in a sup	plemental sample of 2.		whenthere are any actual or	the	
	(Residents #A, C	, D, and 34)		potential detrimental effects to resident. The facility shall ensi		
				errors in medication		
	Findings include:	:		administration are documente		
				the resident's record.Correctiv		
	A policy and prod	cedure for		action for residents affected:R A, C, D and 34- Unable to con		
		ERROR", with a revised		the clinical record.Medications		

Facility ID:

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/09/2011 FORM APPROVED OMB NO. 0938-0391

	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		NSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		B. WING	J		04/08/2011
PROVIDER OR SUPPLIER			44 CHA	ADDRESS, CITY, STATE, ZIP CODE TEAU BLVD VILLE, IN47006	
SUMMARY S' (EACH DEFICIENCE REGULATORY OR date of February the Director of H at 1:05 p.m. The not limited to: "7 the guidelines for established by the medication errors receiving medica services from the be recorded. Me includes: medica assistance with se cuing) and admir staff. A medicati medication, wror timewrong rout The medication E be completed each discovered. ALI the incident must page of the repor medication errors Medication Error in the Administra review" 1. Resident #A's 4/4/11 at 11:24 a. Resident #A was that included, but	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) 2006, was provided by ealth Services on 4/8/11 policy included, but was The facility will follow medication assistance e State of IndianaALL s that occur for residents tion management facility are required to dication management ation set-up, reminders, elf-administration (ex. histration by licensed on error includes: wrong ag dosage, wrong te, missed medication. Error Report form must the time an error is medications involved in the listed on the second at formAll other s shall be recorded on the report and kept on file attor's office for ISDOH record was reviewed on m. The record indicated admitted with diagnoses at were not limited to, bood pressure, depression,		44 CHA	TEAU BLVD	ts cted this ion of t to
congestive heart					

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CON	nstruction 00	(X3) DATE COMPL		
			B. WING			04/08/2	011
	PROVIDER OR SUPPLIER		44 (CHAT	DDRESS, CITY, STATE, ZIP CODE FEAU BLVD VILLE, IN47006		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFI	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	_	DEFICIENCY)		DATE
	1 -	rs for medications for					
		icated orders for the					
	following medicate						
	_	n 650 mg (milligrams)					
	take 1 tablet ever	ry morning (for pain)					
	- Humulin N 100	units/ml (milliliter) vial					
	42 units SQ (sub	cutaneous) every					
	morning before of	or at breakfast (for					
	diabetes)						
	- Glimepiride 4 r	ng table, take 2 tablets					
	daily (for diabete	es)					
	- Lisinopril 20 m	g tablet, one tablet daily					
	(for blood pressu	ire)					
	- Citalopram 10	mg tablet, take 1 daily					
	(for depression)						
	- Prednisone 5 m	g, take 1 tablet daily by					
		cerebellar infarct)					
	1	ng, take 1 capsule by					
		high blood pressure)					
	I	m 4.5 mg every day (One					
		one 2.5 mg tablet) (for					
	blood clot in leg	- · ·					
	1	g by mouth daily (for					
	dementia)						
	· /	mg by mouth two times a					
		od pressure and edema)					
	1	ra strength caplet, 2					
	1 -	e (for pain/sleep)					
	aprote at ocaliii	(Pann					
	Medication admi	nistration records					
		ch 2011 indicated the					
	` ′	ations had been initialed					
	1	als circled to indicate the					
	medication had r	not been give on March 5:					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
			B. WIN	G		04/08/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
CHATEA	LLOE DATECVILLE				TEAU BLVD		
	U OF BATESVILLE			BATES	VILLE, IN47006		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	COMPLETION DATE
IAG			+	IAU			DATE
	2.5 mg tablets	m, both the 2 mg and the					
	- Aricept 5 mg						
	- Furosemide 80	ma					
	- Tylenol PM 2 ta	•					
		autets					
	The explanation	on the back of the MARs					
		/11 5 & 8 pm pills [not]					
		ng on counter this am."					
	No documentation	on of the medication error					
	was found in Res	sident #A's record.					
	2. Resident #C's	record was reviewed on					
	4/6/11 at 11:25 a.	.m. The record indicated					
	resident #C was a	admitted with diagnoses					
	that included, but	t were not limited to,					
	pacemaker, osteo	parthritis, high blood fats,					
	constipation, con	gestive heart failure,					
	hypothyroidism,	high blood pressure,					
	chronic obstructi	ve pulmonary disease					
	(COPD), and bac	ck pain.					
	Physician's order	rs for medications for					
	February 2011, in	ndicated orders for the					
	following medica	ations:					
	- Prednisone 5 m	g 1 each morning (for					
	COPD)						
	- Levothyroxine	88 mcg (micrograms) 1					
	tablet daily (for h	nypothyroidism)					
	- Docusate sodiu	m 100 mg 1 tablet daily					
	(for constipation))					
		0 mg 2 tablet daily (for					
	pacemaker)	- · ·					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
			B. WIN			04/08/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
CHATEA	LLOE DATEOVILLE				TEAU BLVD		
	U OF BATESVILLE			BATES	VILLE, IN47006		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	COMPLETION DATE
IAG			+	IAU			DATE
	blood pressure)	1 tablet daily (for high					
		ma 1 tablet 2 times a day					
	(for congestive h	ng 1 tablet 2 times a day					
	l `	00 mg 1 tablet 2 times a					
		•					
	day (for osteoarth	mg 1 tablet 2 times a day					
	(for congestive h						
	ı `	,					
		tablet once a day at					
	bedtime (for high	g/hour patch, apply one					
		ry 72 hours (for pain)					
	patch to skin eve	ry /2 nours (for pain)					
	MARs for Februa	ary 2011 indicated the					
		ations had been initialed					
	1	rcled which indicated the					
	medication had n						
		28: Crestor, with the					
		d [not] available" on the					
	back of the MAR						
		d 22 at 8:00 a.m. and					
		00 p.m.: Furosemide,					
	1 1	tion "[not] available" on					
	the back of the M						
		•					
	MARs for March	2011 indicated the					
	following medica	ations had been initialed					
	as not given:						
	_	6, and 10: Crestor, with					
	1	on the back of the MAR					
	of "med [not] ava						
	On March 4, the Fentanyl 25 mcg/hr patch						
	was due to be re-	applied, and the box for					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU A. BUII B. WIN	DING	NSTRUCTION 00	(X3) DATE : COMPL 04/08/2	ETED	
	PROVIDER OR SUPPLIER		1	STREET A	DDRESS, CITY, STATE, ZIP CODE TEAU BLVD /ILLE, IN47006	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	that day was cross patch was initialed 5th. The explana MAR indicated: patch was put on out on 4th but no counter." During an interval a.m. the Director indicated a medical should have been patch not being counter. No documentation was found in Resident #D's 4/5/11 at 2:05 p.1 Resident #D was that included, but peripheral vascul			I	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	
	renal disease, vit constipation, and	amin B-12 deficiency, insomnia.					
	February 2011, in following medica - Temazepam 30 (for insomnia) - Aspirin 81 mg, blood pressure)	rs for medications for andicated orders for the ations: mg 1 capsule at bedtime 1 tablet daily (for high azide 25 mg, 1/2 tablet					

006489

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MI	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPI	
			B. WIN			04/08/2	2011
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
				1	TEAU BLVD		
CHATEA	U OF BATESVILLE			BAIES	/ILLE, IN47006		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	daily (for high bl	* /					
		,000 mcg tablet daily (for					
	B-12 deficiency)						
	- Paroxetine 20 r	ng daily (for depression)					
	MARs for Febru	ary 2011 indicated the					
	following medica	ations had been initialed					
	and the initials c	ircled which indicated the					
	medication had r	not been given:					
	- February 16: T	emazepam, with the					
	explanation on the back of the MAR						
	"[not] available".						
	- February 20: A						
	explanation on the	ne back of the MAR					
	"[not] available".						
		d 21: Vitamin B-12, with					
	1	on the back of the MAR					
	"[not] available".						
), 21: Paroxetine, with					
	I -	on the back of the MAR					
	"[not] available".						
	During on interes	iov. on 4/9/11 of 11.54					
		iew on 4/8/11 at 11:54					
		r of Health Services					
		dication was not given					
		vailable, it is considered					
	a medication erro	ЭГ.					
	No documentation	on of the medication error					
	was found in Res	sident D's record.					
	4. Resident #34'	s record was reviewed on					
		.m. The record indicated					
	Resident #34 wa						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
			B. WIN			04/08/2	011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
СПУТЕЛ	LLOE BATEOVILLE			1	TEAU BLVD		
	U OF BATESVILLE				VILLE, IN47006		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		cluded, but were not	-	IAU			DATE
	limited to, high b						
		l reflux disease, high					
	1 ~ ~ ~	nonary high blood					
		tion, arthritis, macular					
	degeneration, ang						
	fibrillation.	gilla, aliu atriai					
	morniation.						
	Physician's order	rs for medications for					
	· ·	icated orders for the					
	following medica						
	_	325 mg, 1 tab every day					
	(anemia)	323 mg, 1 tab every day					
	l ` ′	llequivalents, 1 tab twice					
	a day	nequivalents, I tao twice					
	1	dium 40 mg, 1 tab every					
	day	didili 40 mg, 1 dao every					
	l *	ER, 150 mg, 1 capsule					
	every day	EK, 150 mg, 1 capsule					
	1 -	ICL 180 mg, 1 every day					
		mg, 1 tab at bedtime					
		ng, 1 tab every day					
		mg, 1 tab twice a day					
		mg, 1 tab at bedtime					
	(high cholesterol	•					
	` `	g, 1 tab every Saturday					
	(osteoporosis)	5, I tale every buttinday					
	l ` • •	mg, 1 tab daily (GERD)					
	_	pap 10/325, 1 tab four					
	times a day (pain	• •					
	mines a day (pain	·)					
	MARs for Februs	ary 2011 indicated the					
		ations had been initialed					
	_	ircled which indicated the					
	and the initials ci	itered willen maleated the					

006489

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL B. WINC	DING	00	COMPL 04/08/2	ETED
	ROVIDER OR SUPPLIER		F	STREET A	DDRESS, CITY, STATE, ZIP CODE TEAU BLVD //LLE, IN47006		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
	mg, with the exp the MAR - "[not] dose. The 3/25 d why it had not be A medication dis 3/29/11 indicated 3/28/11 had been No documentation	and 28: Alprazolam 0.5 danation on the back of available" for the 3/24 dose had no explanation een given.					
		ential Rule finding relates 00086981, IN00087366,					
R0297	administers medic facility shall do the (1) Make arranger pharmaceutical se provide residents in accordance with Based on record facility failed to a provided with provided with provided with provided with provided with grant multiple dose medications were This affected 2 or a sample of 7 (Re	ntrols, handles, and ations for a resident, the following for that resident: nents to ensure that rvices are available to with prescribed medications applicable laws of Indiana. review and interview, the ensure residents were escribed medications in es of routinely given e not available. f 7 residents reviewed in esidents #C and D) and 1 riewed in a supplemental	R0.	297	If the facility controls, handles, and administers medications for aresident, the facility shall arrange services with a compliance packaging pharmato ensurethat pharmaceutical services areavailable to provid residents with prescribed medications in accordance with applicable laws of Indiana.	icy e	05/29/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

H6Y911

Facility ID: 006489

If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU	ILTIPLE CO	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
THETETAL	or conduction	BENTH TEATION NOMBER.	A. BUILI			04/08/2011
			B. WING		DDDEGG GITTY GTATE ZID GODE	01/00/2011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE TEAU BLVD	
CHATEA	U OF BATESVILLE				VILLE, IN47006	
(X4) ID	STIMMARVS	TATEMENT OF DEFICIENCIES	\dashv	ID		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	F	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	sample of 2. (Re	esident #34)			Residents are provided with	
					automatic refill cycles of	
	Findings include	d:			prescribed medicationsin that multiple doses of routinely give	en
	_				medications are available.	
	A policy and pro	cedure for			Corrective action for residents	I
		ERROR", with a revised			affected:Resident C, D and 34	k:
	date of February	2006, was provided by			Unable tocorrect the clinical record. Measures to ensure	
	_	Tealth Services on 4/8/11			practice does not	
	at 1:05 p.m. The	policy included, but was			recur:Medication error reports	are
	not limited to: "	The facility will follow			accurately documented and	
	the guidelines for medication assistance established by the State of IndianaALL				kepton file for review by ISDOH.This corrective action	will
					be monitored by:The Director	• • • • • • • • • • • • • • • • • • •
	medication errors that occur for residents				Health Servicesor designee w	
	receiving medica	tion management			be responsible for completing	a
	services from the	e facility are required to			clinical record audit of all residents weekly for 4 weeks,	
	be recorded. Me	dication management			then every other week for8	
	includes: medica	ation set-up, reminders,			weeks, then monthly for 3	
	assistance with s	elf-administration (ex.			months. Results will be report to the QA team for review and	
		nistration by licensed			further corrective actions as	
		ion error includes: wrong			deemed necessary.	
		ng dosage, wrong				
	_	te, missed medication.				
		Error Report form must				
	_	ch time an error is				
		medications involved in				
		t be listed on the second				
		t formAll other				
		s shall be recorded on the				
		report and kept on file				
		ntor's office for ISDOH				
	review"					
	1 D: 1 / //C!	1				
		record was reviewed on				
	4/6/11 at 11:25 a	.m. The record indicated				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING B. WING	00	(X3) DATE COMP 04/08/	LETED	
	PROVIDER OR SUPPLIER		STREE 44 Ch	T ADDRESS, CITY, STATE, ZIP C HATEAU BLVD SVILLE, IN47006	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	that included, bu pacemaker, osted constipation, cor hypothyroidism, chronic obstructi (COPD), and back	•				
	following medic and the initials c medication had r - February 9 and explanation "med back of the MAF - February 21 an February 21 at 4	28: Crestor, with the d [not] available" on the R. d 22 at 8:00 a.m. and :00 p.m.: Furosemide, tion "[not] available" on				
	following medic not given: - February 2, 3, 6	n 2011 indicated the ation had been initialed as 6, and 10: Crestor, with on the back of the MAR ailable".				
	4/5/11 at 2:05 p.: Resident #D was that included, bu peripheral vascu	record was reviewed on m. The record indicated admitted with diagnoses t were not limited to, lar disease, depression, ase, high blood pressure,				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDER/SUPPLIER/CLIA CATION NUMBER:	(X2) MU A. BUIL		00 	COMPL	ETED
			B. WING			04/08/2	UTT
NAME OF 1	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE	-	
					TEAU BLVD		
CHATEA	U OF BATESVILLE			BATESV	/ILLE, IN47006		
(X4) ID	SUMMARY STATEMENT	Γ OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST E			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG	REGULATORY OR LSC IDENT			TAG	DEFICIENCY)		DATE
	renal disease, vitamin B-	•					
	constipation, and insomn	ia.					
	MARs for February 2011 following medications had and the initials circled whemedication had not been - February 16: Temazepa explanation on the back of "[not] available" February 20: Aspirin, we explanation on the back of "[not] available" February 17 and 21: Vista the explanation on the back of "[not] available" February 19, 20, 21: Pathe explanation on the back of "[not] available".	and been initialed which indicated the given: am, with the sof the MAR with the sof the MAR itamin B-12, with the sof the MAR aroxetine, with					
	3. Resident #34's record 4/7/11 at 10:45 a.m. The Resident #34 was admitted diagnoses that included, I limited to, high blood pregastroesophageal reflux of cholesterol, pulmonary high pressure, depression, arthedegeneration, angina, and fibrillation. MARs for February 2011 following medications has	e record indicated ed with but were not essure, disease, high igh blood nritis, macular d atrial					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
			B. WIN	G		04/08/2	011
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					TEAU BLVD		
CHATEA	U OF BATESVILLE			BATES	VILLE, IN47006		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		rcled which indicated the					
	medication had n	•					
	- March 24, 25, a	nd 28: Alprazolam 0.5					
	mg, with the expl	lanation on the back of					
	the MAR - "[not]	available" for the 3/24					
	dose. The 3/25 d	lose had no explanation					
	why it had not be	een given.					
	During an intervi	ew on 4/8/11 at 11:54					
	_	r of Health Services					
		lity's protocol was to					
	circle the med not given, write the reason						
		e MAR, try to get the					
	med in, and they						
	medication) was	•					
	inedication) was	ordered.					
	This State Poside	ential Rule finding relates					
		•					
	to complaints IN0 IN00087411.	0008/300 and					
	IN0008/411.						
R0298	(2) A consultant ph	narmacist shall be					
R0270		er contract, and shall:					
		for the duties as specified					
	in 856 IAC 1-7;						
		g handling and storage					
	practices in the fac	tation on methods and					
	procedures of orde						
		I disposing of drugs as well					
	as medication reco						
		ng, to the administrator or					
		e any irregularities in iinistration of drugs; and					
		g regimen of each resident					
		rvices at least once every					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/08/2011
	PROVIDER OR SUPPLIER		44 CHA	ADDRESS, CITY, STATE, ZIP CODE ATEAU BLVD VILLE, IN47006	0.000.2011
	SUMMARY S (EACH DEFICIENT REGULATORY OR Sixty (60) days. Based on record facility failed to dereviews were conducted for the review of the reviewed on 4-4-of the "Consultar Regimen Review review was conducted for the review with t	review and interview, the ensure drug regimen aducted every 60 days for esidents. (Resident #38) inical record was 11 at 11:45 a.m. Review at Pharmacist Drug reform indicated no drug ucted between the dates -8-10, indicating a period een drug reviews. the Director of Nursing at 3:14 p.m., she ald not find any other Resident #38 for the time	STREET A	ATEAU BLVD VILLE, IN47006 PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIDEFICIENCY) If the facility controls, handle and administers medications resident, the facility shall arraservices with a compliance packaging pharmacy to ensure that pharmaceutical services available to provide residents with prescribed medications accordance with applicable la of Indiana. Residents are provided with automatic refile cycles of prescribed medication in that multiple doses of routing given medications are available Corrective action for reside affected: Resident C, D and 34: Unable correct the clinical record. Measures to ensure practice does not recur: Medication error reports are accurately documented and key on file for review by ISDOH. This corrective action will be monitored by:	DATE 05/29/2011 es, for a lange re lare sin laws Il ons inely ble. nts e to e lept pe
				The Director of Health Service or designee will be responsible for completing a clinical reconstruction and the service and the service and the service and the service at the service and the service at the service and the	ord for 4 c for

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MI A. BUII B. WIN	LDING G	ONSTRUCTION 00 ADDRESS, CITY, STATE, ZIP CODE	(X3) DATE : COMPL 04/08/2	ETED
	PROVIDER OR SUPPLIER U OF BATESVILLE			44 CHA	ATEAU BLVD VILLE, IN47006		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
R0300	facility must be lat currently accepted include the appropriate cautionary instruct date. Based on observation ensure proper lab counter (OTC) may be a supplemental streviewed for phase (Resident #4) Findings included Resident #4's roomat 2:45 p.m. with Director and (Face environmental to bottles of over-the labeled as Tylend MegaRed, were counter near the labeled as the counte	and biologicals used in the beled in accordance with a professional principles and briate accessory and the expiration attion, the facility failed to beling of 3 over the medications found in 1 of ampled residents remaceutical compliance. The Maintenance cility Director during the facility Director durin	RO	0300	Over-the-counter medications, prescription drugge andbiologicals used in the fact arelabeled in accordance with currently accepted professions principles including appropriat accessory and cautionary instructions and expiration dat Corrective action for residents affected:Res 4 - unable to contheclinical record citation. Medications, including, over-th counter medications are labeled stored, administered and documented in accordance wi MD orders. Other residents ha the potential to be affected an corrective actions: All residents with over-the-counter medicat have the potential to be affect by this deficient practice. Medications, including, over-the-counter medications labeled, stored, administered a documented in accordance wi MD orders. This corrective act will be monitored by: The Direct of Health Servicesor designed be responsible for completing OTC Medication audits of all residents weekly for4 weeks, the every other week for 8 weeks, then monthly for 3 months.	ility al al al ae de. arect ed, th ving d s ions ed are and th tion ctor e will	05/29/2011

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLI	ECONSTRUCTION	ř ,	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00		PLETED
			B. WING		04/08	/2011
NAME OF I	PROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP COD	E	
NAME OF I	KO VIDEK OK SOI I EIEK		44 0	CHATEAU BLVD		
CHATEA	U OF BATESVILLE		BAT	ESVILLE, IN47006		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX		LD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	TOT TUTTE	DATE
R0302	identified with the (A) Resident name (B) Physician name (C) Expiration date (D) Name of drug. (E) Strength. Based on observation ensure proper lab counter (OTC) may be a supplemental streviewed for phase (Resident #4) Findings include: Resident #4's room at 2:45 p.m. with Director and Site environmental to bottles of over-the labeled as Tylend MegaRed, were counter near the labeled as counter near the labeled as the counter near the label	e. ation, the facility failed to beling of 3 over the hedications found in 1 of hampled residents rmaceutical compliance. In the Maintenance Director during the heur. During this tour, 3 he counter medications, ol, Pepto Bismol and observed on the kitchen kitchen sink. These erved to have only the	R0302	Results will be reported to team for review and furth corrective actions as deen necessary. Over-the-counter medical areidentified with the resiname, physician name, edate, name of drug and some corrective action for resident affected: Resident #4: Uncorrect the clinical record medications have proper labeling. Other residents the potential to be affected corrective actions: Reside OTC medications have proper labeling. Measures to enspractice does not recur: Nolicies and procedures to medication administrated documentation of same, monitoring for side effect been implemented. This corrective action will be residential to the potential effect to medication administrated documentation of same, monitoring for side effect the potential to the potential effect to medication administrated documentation of same, monitoring for side effect the potential effect action will be residential effect action will be residential effect actions for all residential	tions dent expiration strength. dents able to OTC having ed and ents with DTC sure lew relative tion, and s have	05/29/2011
R0304	shall be appropria	eatment cabinets or rooms tely locked at all times prized personnel are				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	1	
			B. WIN	G		04/08/2	2011
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
				1	ATEAU BLVD		
CHATEA	U OF BATESVILLE			BATES	VILLE, IN47006		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		dule II drugs administered					
		Il be kept in individual double lock and stored in a					
		tructed box, cabinet, or					
	mobile drug stora						
		ation, interview and	R(304	Medicine or treatment cabine	ts	05/29/2011
		ne facility failed to ensure			orrooms are appropriately loc	ked	
		s were double locked at			at all times except when authorized personnel are pres	cent	
	_	supervised by authorized			All Schedule II drugs	ociii.	
		deficient practice has the			administered by the facility ar	е	
	•	rsely affect all resident			kept in individual containers		
	who have curren	-	under double lock and stored				
	medications.				substantially constructed box, cabinet, ormobile drug storage		
	incurcuis.				unit. Corrective action for	C	
	Findings include	÷			residents affected:The facility		
	1 mamgs merade	•			shall ensure ScheduleII drugs are		
	On 4-7-11 at 4:2	7 p.m., an unattended			double locked at all times and	l/or	
		ion cart was observed to			supervised by authorized personnel. Other residents ha	vina	
		or hallway, near room #			the potential to be affected ar		
		on shelf of the cart was a			corrective actions:This deficie	ent	
		sembled a fishing tackle			practice has thepotential to		
	•	•			adversely affect all resident w have current Schedule II	/no	
	_	lar lock. A box similar to			medications.		
	•	eviously identified by the ing (DON) as the					
		. ,					
	•	ox in which narcotics or					
		ications are stored and					
		locked inside a cabinet in					
		ng Office. This cart and					
		nded by any facility staff					
	for two minutes,	until 4:29 p.m.					
		T. D. T. 110					
		n LPN #3 on 4-7-11 at					
	*	dicated her normal					
	•	ssing medications is to					
	take the locked n	narcotic box (tackle box)					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
			A. BUILDING B. WING		04/08/2011
	ROVIDER OR SUPPLIER		44 CH	ADDRESS, CITY, STATE, ZIP CODE ATEAU BLVD VILLE, IN47006	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	that she "just fo when the observa the same afternoon On 4-8-11 at 4:40				
	11 residents with medications and	a total of 16 Schedule II 494 doses of medication ontained in the locked			
R0349	on each resident. maintained under employee of the fa responsibility. The follows: (1) Complete. (2) Accurately doc (3) Readily access (4) Systematically Based on record	sible. organized. review and interview,	R0349	The facility maintains clinicalrecords that are comple	05/29/2011
	accurate clinical that nurse's notes times and/or sign members that madocumentation for blood sugar testin record. This affe sample of 7. (Re #38)	de the entry, and or hourly checks and ng was not in the clinical ected 2 of 7 residents in a sident #C and Resident		accurately documented, readil accessible, and systematically organized. Corrective action for residents affected: Res C: unal to correct the clinical record citation. Accurateclinical documentation within the nursinotes includes times and/or signature of the staffmember the made the entry. Medications are administered and documented accordance with MD orders. Research as a unable to correct the clinical record citation. Accurate clinical	r bble ing hat re I in es
	Findings include	•		documentation of hourly check	l l

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

H6Y911

Facility ID:

006489

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUII	LDING	00	COMPLETED		
			B. WIN	G		04/08/20	011
NAME OF PROVIDER OR SUPPLIER				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF TROVIDER OR SOFT EIER				44 CHA	ATEAU BLVD		
CHATEAU OF BATESVILLE					VILLE, IN47006		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	<u> </u>		DATE
	1 D: 1 //Cl.				and blood sugar testing within clinical record are completed a		
		record was reviewed on		service plan updated.			
		.m. The record indicated			Medications are administered	and	
	Resident #C was	admitted with diagnoses			documented in accordance with	th	
	that included, but	t were not limited to,			MD orders. Other residents		
	congestive heart	failure, high blood			having the potential to be affect	cted	
	pressure, and ost	eoarthritis.			and corrective actions:All residents have the potential to	he	
					affected by this deficient practi		
	The following nu	rse's notes failed to			Clinical and	-	
	_				MedicationAdministration		
	include the time the entry was made: 2/28/11 (2 entries), 3/1/11, 3/3/11, 3/6/11, 3/10/11 (2 entries), 3/13/11, 3/14/11 (2 entries), and 3/15/11.				Records for April have been		
					reviewed, and documentation		
					complete and accurate.Measu	res	
					to ensure practice does not recur:New policies and		
					proceduresrelative to medicati	on	
	A nurse's note en	try dated 3/9/11 at 1445			management, clinical records,		
	(2:45 p.m.) failed	l to include any			and service planning have bee	en	
	documentation as	nd had two blank lines			implemented. All qualified hea	lth	
	after the date and	l time.			services staff has been		
					in-serviced on the		
	An entry dated 3	/13/11 failed to include			procedures. This corrective act will be monitored by: The Directive act		
		title of the person that			of Health Services or designed		
	made the entry.	title of the person that			will be responsible for completi		
	made the entry.				audits of clinical and medication	٠ ،	
		4/6/11 + 5.00			administration records for		
	_	iew on 4/6/11 at 5:02			residents receivingmedication		
	* ′	r of Health Services			administration services weekly		
	indicated nurse's				4 weeks, then every other weeks, then monthly for 3		
	supposed to be si	gned and have dates and			months.Results will be reporte		
	times.				the QA team for review and	0	
					further corrective actions as		
					deemed necessary.		
	2. Resident #38's clinical record was				The facility maintains		05/29/2011
	reviewed 4-4-11	at 11:45 a.m. Her			clinicalrecords that are comple		
	diagnoses include	ed, but were not limited			accurately documented, readil		
	_	iabetes mellitus type 2,			accessible, and systematically organized. Corrective action fo		
					organized.Corrective action to	'	

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUII	BUILDING 00		COMPLETED		
		B. WIN			04/08/2011		
NAME OF PROVIDER OR SUPPLIER				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				1	ATEAU BLVD		
CHATEAU OF BATESVILLE				BATES	VILLE, IN47006		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	,	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	DATE	
		failure and coronary			residents affected:Res C: unal to correct the clinical record	ole	
	artery disease.				citation. Accurateclinical		
					documentation within the nurs	ing	
		f her blood glucose			notes includes times and/or		
	(blood sugar) res	ults were documented on			signature of the staffmember t		
	a form entitled, '	'Blood Sugar Test," as			made the entry. Medications ar administered and documented		
	well as located or	n the Medication			accordance with MD orders.Re		
	Administration R	tecord (MAR) and within			38: unable to correct the clinic		
		ress notes. The ability to			record citation. Accurate clinic	al	
		ends in this resident's			documentation of hourly check		
	blood sugar (BS)				and blood sugar testing within		
	difficult as the "Blood Sugar Test" log was not used routinely to record all				clinical record are completed a service plan updated.	iriu	
					Medications are administered	and	
		ample, between the time			documented in accordance with	h	
	-	ntil 3-4-11, there were no			MD orders. Other residents		
	_	ngs recorded on the log.			having the potential to be affect	eted	
		ted on 3-9-11 that the BS			and corrective actions:All residents have the potential to	he	
					affected by this deficient practi		
		ysician-ordered to be			Clinical and		
		vice weekly to twice			MedicationAdministration		
	-	and 4:00 p.m. The			Records for April have been		
		hat when the BS readings			reviewed, and documentation complete and accurate.Measu		
		ekly, the actual numerical			to ensure practice does not		
	_	corded on the MAR, as			recur:New policies and		
		d Sugar Test" log. When			proceduresrelative to medicati	on	
	_	were increased to twice			management, clinical records,		
	daily, the staff re	_			and service planning have bee implemented. All qualified hea		
		test had been conducted,			services staff has been		
		the MAR, with the			in-serviced on the		
	exception of 6 occasions, but did not indicate what time the results were obtained. On the 6 occasions that the				procedures. This corrective act		
					will be monitored by:The Direct		
					of Health Services or designee will be responsible for completi		
	results were reco	rded on the twice daily			audits of clinical and medication		
	section of the MA	AR, it only indicated the			administration records for		
		one time each on those			residents receivingmedication		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	00	COMPL			
AND TEAR OF CORRECTION IDEA THO THOUSANDER.		A. BUILDING		04/08/2011				
			B. WIN			04/00/2	311	
NAME OF PROVIDER OR SUPPLIER				1	ADDRESS, CITY, STATE, ZIP CODE			
CHATEAU OF BATESVILLE			44 CHATEAU BLVD BATESVILLE, IN47006					
					· · · · · · · · · · · · · · · · · · ·	-	(2/5)	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE	
	dates. Additiona	ally, for BS results			administration services weekl			
		MAR and Blood Sugar			4 weeks, then every other we			
		1 at 8:30 a.m., it			for 8 weeks, then monthly for			
	_	was very low at 25, but			months.Results will be reported the QA team for review and	של נט		
		l not reflect what care, if			further corrective actions as			
	any was provided. On 3-3-11, no BS was recorded on the MAR or Blood Sugar Test				deemed necessary.			
	log, but nursing	notes at 3-3-11 at 8:10						
	a.m. indicated, ".	BS taken this AM						
	(morning) due to	found on floor in room						
	very confused. G	Save glucose and oj						
	(orange juice.) Checked BS again at 8:45							
	a.m. up to 96 (wi	ithin normal range.)"						
	This entry did no	ot indicate what the						
	original BS readi	ing was at 8:10 a.m.						
	Review of the Bl	lood Sugar Test Log,						
	nursing notes and	d MAR entries for the						
		ough 4-1-11 indicated						
	numerical BS res							
		3-14 morning, 3-18 only						
		ith no indication of a.m.						
		ther morning or evening						
	I -	orning; 3-25 morning;						
	I -	-27 morning; 3-28						
	T -	vening; 3-30 morning;						
	ı	Review of Resident						
		t A1C test (test for degree						
		od sugars over the last 3						
	/ ·	-13-11 indicated it was						
		at 12.2 (goal is to be less						
	than 6.0).							
		1 . 1 1 2 . 4						
		was located during the						
	clinical record re	eview of a form entitled,						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/09/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED		
			B. WING			- 04/08/2011	
NAME OF PROVIDER OR SUPPLIER CHATEAU OF BATESVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 44 CHATEAU BLVD BATESVILLE, IN47006				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		E	(X5) COMPLETION DATE
	3-6-11 routine horinitiated on Residindicated the free following day to continued until 3 nursing notes and indicate for what checks were initiated on 3-29 were discontinue Director of Nursip.m., she indicated been initiated due hypoglycemia pro	-					
R0406	(a) The facility must establish and maintain an infection control practice designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection. Based on observation, record review, and interview, the facility failed to ensure staff were handling resident's medications in a safe and sanitary manner in that one staff member counted narcotics with her bare hands. This affected 1 of 7 residents observed during the medication pass. (Resident #34)		R0406	e c c a a a i i	The facility has developed, and implemented infection cont policies and procedures to ensecontrolled practices designed to provide a safe, sanitary, and comfortable environment and help prevent the development transmission of diseases an fection. Corrective action for esidents affected: Res 34: Una	ure o ent and	05/29/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

H6Y911

Facility ID:

006489

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING		(X3) DATE SURVEY COMPLETED 04/08/2011				
			B. WING		04/08/2011			
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 44 CHATEAU BLVD					
CHATEAU OF BATESVILLE			BATE	SVILLE, IN47006				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
PREFIX	Findings include A medication pare on 4/4/11 at 12:5 During the observed as she count of Vicodin The LPN cleaned sanitizing lotion, towel on top of the administration between the LPN then count of the LPN then counted the pidd not come out pills with her bare LPN said she used bare hands becaut anything else to the LPN then counted the pidd not come out pills with her bare LPN said she used bare hands becaut anything else to the LPN then counted the pidd not come out pills with her bare LPN said she used bare hands becaut anything else to the LPN then counted the pidd not come out pills with her bare LPN said she used bare hands becaute anything else to the LPN the Administration of the LPN then counted the pidd not come out pills with her bare LPN said she used bare hands becaute anything else to the LPN then counted the pidd not come out pills with her bare LPN said she used bare hands becaute anything else to the LPN then counted the pidd not come out pills with her bare LPN said she used bare hands becaute anything else to the LPN then counted the pidd not come out pills with her bare LPN said she used bare hands becaute anything else to the LPN then counted the pidd not come out pills with her bare LPN then counted the pidd not come out pills with her bare LPN then counted the pidd not come out pills with her bare LPN then counted the pidd not come out pills with her bare LPN then counted the pidd not come out pills with her bare LPN then counted the pidd not come out pills with her bare LPN then counted the pidd not come out pills with her bare LPN then counted the pidd not come out pills with her bare LPN then counted the pidd not come out pills with her bare LPN then counted the pidd not come out pills with her bare LPN then counted the pidd not come out pills with her bare the pidd not come out pills with her bare the pidd not come out pills with her bare the pidd not come out pills with her bare the pidd not come out pills with her bar	cy Must be perceded by full LISC IDENTIFYING INFORMATION) : ss observation was done 0 p.m. with LPN #4. vation, LPN #4 was completed a narcotic 10/325 for Resident #34. d her hands with a placed a clean paper the open medication book and poured the le onto the paper towel. So butted the pills using her rouping the pills in piles ting the piles. She lls when the first count a right, and touched all the refingers again. The led the paper towel and her use she didn't have	PREFIX	to correct the04/04/11 medical pass observation. Medication are administered using safe a sanitary practices. Other residently procedures relative to Medication are administered using safe a sanitary practices. Other residently practices actions: All residents, to which, thefacility administers medications for, the potential to be affected by deficient practice. Policies and procedures relative to Medical Administration and Infection Control are in place to ensure professional standards of medication administration. Of April 27, 2011 all staff qualifical administer medications were inserviced on Infection Control and Medication Management Measures to ensure practice does not recur: Policies and procedures relative to Medical Administration and Infection Control are in place to ensure professional standards of medication administration. Of April 27, 2011 all staff qualifical administer medications were inserviced on Infection Control and Medication Administration. This corrective action will be monitored by: The Director of Health Servicesor designee will be responsible completing an observational medication pass audit on all squalified to administer.	ation is and dents ected / have / this id tion ect to ol i tion ect to ol i tion ect to ol i			
	"Medication Management - Medication Administration" with an effective date of 4/7/11. The policy included, but was not limited to: "L. Apply professional			medications weekly for 4 week then every other week for 8 weeks, then monthly for 3 months. Results will be report				
				to the QA team for review and				

006489

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/09/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING B. WING			COMPLETED 04/08/2011			
NAME OF PROVIDER OR SUPPLIER CHATEAU OF BATESVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 44 CHATEAU BLVD BATESVILLE, IN47006					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	ILD BE	(X5) COMPLETION DATE		
	standards of prac policy, Standard	tice as defined in facility Precautions, and astructions for the proper istering different		further corrective actions deemed necessary.	as			

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